STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING _____ B. WING _____	C 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILLS CENTER FOR REHABILITATION AND HEALING	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation #53397 and #53515 was completed on 3/23/2021 at Green Hills Center for Rehabilitation and Healing. Deficiencies were cited related to the complaint #53515 under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, observation, and interview, the facility failed to provide services to prevent wrongful exit from the facility for 1 (Resident #2) of 4 residents reviewed. The findings include: Review of the undated facility policy titled "Abuse, Neglect and Exploitation of Residents" showed it was the policy of the facility that neglect was	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 absolutely prohibited. It was also showed that each resident has the right to be free from neglect. Review or the medical record showed Resident #2 was admitted to the faciity on 6/5/19 with diagnoses which included Atrial Fibrillation, Diabettes Mellitus, and Dementia with and without Behavioral Disturbance and Altered Mental Status. Review of the medical record of the Quarterly Minimum Data Set (MDS) dated 1/23/2021 revealed Resident #2 scored 10 on the Brief Interview for Mental Status (BIMS) indicating some loss of cognitive function. Review of the medical record for Resident #2 showed the nursing progress notes had no documentation of a wander guard (individual elopement alarm device) before 3/8/2021. Continued review showed no documentation of random exit seeking behaviors at the elevator by Resident #2 before 3/8/2021. Observation of the 1st floor back service hall showed no video cameras were present. Continued observation of the back parking lot outside the back service hall egress door showed no video cameras were present. During an interview conducted on 3/22/2021 at 12:25 PM with the Maintenance Director confirmed the back service hall and back parking lot had no video cameras. During an interview conducted on 3/22/2021 at 2:35 PM with Licensed Practical Nurse (LPN) #3 confirmed the nursing progress notes for	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 2 Resident #2 did not reflect exit seeking behaviors before 3/8/2021. Continued review confirmed documentation of the application and removal of the wander guard was not reflected before 3/8/2021. During an interview conducted on 3/22/2021 at 3:30 PM with the Director of Nursing (DON) and Corporate Clinical Nurse confirmed the back service hall and back parking lot had no video cameras. Continued interview confirmed no documentation before 3/8/2021 in the medical record to reflect exit seeking behaviors of Resident #2. Further interview confirmed no documentation before 3/8/2021 of application and removal of the wander guard for Resident #2. Continued interview with the DON and Corporate Clinical Nurse confirmed Resident #2 was able to exit from the facility of her own power on 3/8/2021.	F 600		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, observation, and interview, the facility failed to provide an environment free from accidental hazards over which the facility should have control and supervision for 1 (Resident #2) of 4	F 689		

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F 689	Continued From page 3 residents reviewed. The findings include: Review of the undated facility policy "Accidents and Incidents-Investigating and Reporting" showed all accidents or incidents involving residents occurring on the premises shall be investigated and reported. Continued review showed an investigation of the accident or incident shall be promptly investigated. Review or the medical record showed Resident #2 was admitted to the faciity on 6/5/19 with diagnoses which included Atrial Fibrillation, Diabettes Mellitus, and Dementia with and without Behavioral Disturbance and Altered Mental Status. Review of the medical record of the Quarterly Minimum Data Set (MDS) dated 1/23/2021 revealed Resident #2 scored 10 on the Brief Interview for Mental Status (BIMS) indicating some loss of cognitive function. Review of the medical record showed nursing progress notes with no documentation of placement or removal of a wander guard (individual elopement alarm device) before 3/8/2021. Continued review showed no documentation of exit seeking behaviors at the elevator before 3/8/32021. Review of the facility investigation dated 3/8/2021 for Resident #2 showed at 12:45 PM the resident was able to exit the facility through the egress door of the back 1st floor service hall. Continued review showed Resident #2 self-propelled down the sidewalk approximately 33 feet and slid out of	F 689		

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F 689	Continued From page 4 her wheel chair (WC) at the end of the sidewalk. Observation of the 1st floor back service hall showed no video cameras were present. Continued observation of the back parking lot outside the back service hall egress door showed no video cameras were present. During an interview conducted on 3/22/2021 at 12:25 PM with the Maintenance Director confirmed the 1st floor back service hall and back parking lot had no video cameras. Continued interview confirmed Resident #2 was able to exit the facility through the egress door from the 1st floor back service hall into the back parking lot. During an interview conducted on 3/22/2021 at 2:35 PM with Licensed Practical Nurse (LPN) #3 showed she had observed Resident #2 at the elevator pushing on the doors and the walls on either side of the elevator. LPN #3 stated she had redirected Resident #2 from exit seeking behaviors at the elevator. LPN #3 also stated Resident #2 had a wander guard applied after she was admitted. LPN #3 further stated Resident #2 would removed the wander guard and have it reapplied frequently during the first 2 months after admission. LPN #3 confirmed there was no documentation in the nursing progress notes before 3/8/2021 about the wander guard or exit seeking behaviors by the resident. During an interview conducted on 3/22/2021 at 3:30 PM with the Director of Nursing (DON) and Corporate Clinical Nurse confirmed the back service hall and back parking lot had no video cameras. Continued interview confirmed no documentation before 3/8/2021 in the medical record to reflect exit seeking behaviors of	F 689		

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F 689	Continued From page 5 Resident #2. Further interview confirmed no documentation before 3/8/2021 of application and removal of the wander guard for Resident #2. Continued interview with the DON and Corporate Clinical Nurse confirmed Resident #2 was able to exit from the facility by her own power on 3/8/2021.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		

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F 842	Continued From page 6 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, and interview the facility failed to ensure	F 842		

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F 842	Continued From page 7 sufficient documentation in the medical record for behaviors and device placement for 1 of 3 sampled residents (Resident #2) which failed to reflect the resident's progress with exit seeking behaviors and wander/elopement alarms. The findings include: Review of the undated facility policy titled "Elopements" showed the staff should promptly report any resident who tries to leave the premises. The charge nurse shall document in the resident's medical record. Review or the medical record showed Resident #2 was admitted to the faciity on 6/5/19 with diagnoses which included Atrial Fibrillation, Diabettes Mellitus, and Dementia with and without Behavioral Disturbance and Altered Mental Status. Review of the medical record of the Quarterly Minimum Data Set (MDS) dated 1/23/2021 revealed Resident #2 scored 10 on the Brief Interview for Mental Status (BIMS) indicating some loss of cognitive function. Review of the nursing progress notes dated 6/2019 to 3/2020 showed no documentation of placement or removal of a wander guard (individual elopement alarm device). Continued review showed no documentation of exit seeking behaviors at the elevator. Further review of nursing progress notes dated 4/2020 to 2/2021 showed no documentation of placement or removal of a wander guard or exit seeking behaviors. During an interview conducted on 3/22/2021 at	F 842		

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F 842	Continued From page 8 2:25 PM with Certified Nursing Assistant (CNA) #3 showed she had worked at the facility for 1 year. CNA #3 stated she had been required to redirect Resident #2 from the elevator doors on a couple of occasions this year. CNA #3 also stated Resident #2 was observed to be in her wheelchair (WC) pushing and prying at the elevator doors. CNA #3 further stated the resident was observed pushing on the walls on either side of the elevator doors. CNA #3 stated she reported the exit seeking behaviors and redirection to the charge nurse. During an interview conducted on 3/22/2021 at 2:35 PM with Licensed Practical Nurse (LPN) #3 showed she had observed Resident #2 at the elevator pushing on the doors and the walls on either side of the elevator. LPN #3 stated she had redirected Resident #2 from exit seeking behaviors at the elevator. LPN #3 also stated Resident #2 had a wander guard applied after she was admitted. LPN #3 further stated Resident #2 would removed the wander guard and have it reapplied frequently during the first 2 months after admission. LPN #3 confirmed there was no documentation in the nursing progress notes about the wander guard or removal by the resident. During an interview conducted on 3/22/2021 at 2:45 PM with CNA #4 showed he had observed exit seeking behaviors by Resident #2 and reported the behaviors to the charge nurse. During an interview conducted on 3/22/2021 at 3:30 PM with the Director of Nursing (DON) and the Corporate Clinical Nurse confirmed there was no documentation in the nursing progress notes about placement or removal of the wander guard.	F 842		

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F 842	Continued From page 9 They also confirmed there was no documentation of exit seeking behaviors reported by CNA #3, LPN #3, and CNA #4.	F 842		

GHC

Plan of Correction

Concern	How the corrective action will be accomplished for any resident affected by deficient practice	How we identified other residents/areas that could potentially be affected.	Measures put in place or systemic changes made to ensure that the deficient practice will not recur	How the concern will be monitored and title of person responsible for monitoring.	Dates when concern will be completed.
	Element 1	**Element 2**	**Element 3**	**Element 4**	
F 600— Facility failed to provide services to prevent wrongful exit from facility for 1 of 4 residents.	Wandergaurd was placed on Resident #2 on 3/08/2021 and care plan was updates. Administrator obtained bids for placement of a video camera surveillance system and obtained bid for elevator keypads to be installed on the 2nd floor. Maintenance Director checked all exterior exit and all found to be in operational order according to manufacturer's guidelines on 3/08/2021.	IDT team reviewed the medical records of residents identified as being at risk for an elopement. The IDT Team completed a current elopement risk evaluation of the identified residents. The IDT team has reviewed the plan of care for these residents. The Director of Nursing validated the placement and functionality of all resident's wander guard devices and all were noted to be functioning without difficulty. Elopement Binders were updated with all residents deemed at risk for elopement and placed at each nurse station and front desk	The Staff Development Coordinator provided education to the staff regarding Elopements, Abuse and Neglect, Resident Rights, Wandergaurd System and How to Identify Residents that are an elopement risk from 3/08/2021 to 4/07/2021. The Staff Development Manager will continue to provide education to current staff as indicated and to new staff members during the orientation process. Keypads were added to the elevators (2) on the second floor. A pin number must be entered to access elevator Security camera will be installed at exit doors in the facility by the end of April 2021.	The DON or designee will audit the medical records of residents identified as being at risk for elopement weekly for four weeks then monthly for three months to validate compliance. The DON or designee will audit Elopement Binders weekly for four weeks then monthly for three months to validate that they are updated. Maintenance to check all exterior doors weekly for four weeks then monthly for three months to validate doors are secure and working according to manufactures guidelines. The results of all audits will be presented to the QAPI Committee for review and feedback. Responsible Party: DON	Date of Completion: 4/08/2021

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BY:

GHC

Plan of Correction

Concern	How the corrective action will be accomplished for any resident affected by deficient practice	How we identified other residents/areas that could potentially be affected.	Measures put in place or systemic changes made to ensure that the deficient practice will not recur	How the concern will be monitored and title of person responsible for monitoring.	Dates when concern will be completed.
	Element 1	Element 2	Element 3	Element 4	
F 689— Facility failed to provide an environment free from accidental hazards over which the facility should have control and supervision	Wandergaurd was placed on Resident #2 on 3/08/2021 and care plan was updated. Administrator obtained bids for placement of a video camera surveillance system and obtained bid for elevator keypads to be installed on the 2nd floor elevators (2). Maintenance Director checked all exterior exits and all found to be in operational order according to manufacturer's guidelines on 3/08/2021.	IDT team reviewed the medical records of residents identified as being at risk for an elopement. The IDT Team completed a current elopement risk evaluation of the identified residents. The IDT team has reviewed the plan of care for these residents. The Director of Nursing validated the placement and functionality of all resident's wander guard devices and all were noted to be functioning without difficulty. Elopement Binders were updated with all residents deemed at risk for elopement and placed at each nurse station and front desk.	The Staff Development Coordinator provided education to the staff regarding Elopements, Abuse and Neglect, Resident Rights, Wandergaurd System and How to Identify Residents that are an elopement risk from 3/08/2021 to 4/07/2021. The Staff Development Manager will continue to provide education to current staff as indicated and to new staff members during the orientation process. Keypads were added to the elevators (2) on the second floor. A pin number must be entered to access elevator Security camera will be installed at exit doors in the facility by the end of April 2021.	The DON or designee will audit of the medical records of residents identified as being at risk for elopement weekly for four weeks then monthly for three months to validate compliance. The DON or designee will audit Elopement Binders weekly for four weeks then monthly for three months to validate that they are updated. Maintenance to check all exterior doors weekly for weeks then monthly for three months to validate doors are secure and working according to manufactures guidelines. The results of all audits will be presented to the QAPI Committee for review and feedback.	Date of Completion: 4/07/2021

GHR

Plan of Correction

Concern	How the corrective action will be accomplished for any resident affected by deficient practice	How we identified other residents/areas that could potentially be affected.	Measures put in place or systemic changes made to ensure that the deficient practice will not recur	How the concern will be monitored and title of person responsible for monitoring.	Dates when concern will be completed.
	Element 1	Element 2	Element 3	Element 4	
F 842— Facility failed to ensure sufficient documentation in the medical record for behaviors and device placement for 1 of 3 residents which failed to reflect the residents progress with exit seeking behaviors and wander/elopement alarms.	Resident #2 medical record was updated to reflect placement of wanderguard device, exit seeking behaviors and elopement assessment by the Director of Nursing on 3/08/2021.	IDT team reviewed the medical records of residents identified as being at risk for an elopement. Any negative findings were corrected, and medical records updated. The IDT Team completed a current elopement risk evaluation of the identified residents. The IDT team has reviewed the plan of care for these residents.	The Staff Development Coordinator provided education to all staff on exit seeking behavior documentation in resident medical record. Per policy, any exit seeking behaviors are to be verbalized to the Charge Nurse and then the Charge Nurse will document behaviors in the patient medical record. Education provided from 3/08/2021 to 4/07/2021. The Staff Development Manager will continue to provide education to current staff as indicated and to new staff members during the orientation process. 24H Report books were purchased for each nursing station to make all staff aware of these behaviors. DON or Designs with inquire daily in clinical meeting about any exit seeking behaviors.	The DON or designee will audit medical record of residents with wander guards and residents deemed elopement risk weekly for four weeks then monthly for three months to ensure sufficient documentation is in the medical record. The DON or designee will audit the 24H Report for documentation of exit seeking behaviors daily x 30 days then weekly x four weeks to ensure appropriate actions are taken The results of all audits will be presented to the QAPI Committee for review and feedback. Responsible Party: DON	Date of Completion: 4/08/2021